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FISCAL IMPACT STATEMENT

LS 7806
BILL NUMBER: HB 1678

NOTE PREPARED: May 14, 2007
BILL AMENDED: Apr 29, 2007

SUBJECT: Health Matters.

FIRST AUTHOR: Rep. Brown C
FIRST SPONSOR: Sen. Miller

BILL STATUS: Enrolled

FUNDS AFFECTED: X **GENERAL**
DEDICATED
FEDERAL

IMPACT: State

Summary of Legislation: *Cigarette Tax Increase:* This bill increases the Cigarette Tax by 44 cents per pack to fund various health-related expenses.

Indiana Check-up Plan: The bill establishes the Indiana Check-up Plan and the Indiana Check-up Plan Trust Fund. It specifies requirements for the plan, including coverage, financial assistance, eligibility and enrollment, contracting, financial obligations, and funding requirements. The bill requires application for necessary federal Medicaid approvals, including approval for presumptive eligibility for certain pregnant women and implementation of the Plan. It also establishes a Plan task force.

Indiana Comprehensive Health Insurance Association (ICHIA): The bill requires ICHIA to administer plan benefits for high-risk individuals insured under the plan.

Medicaid and CHIP Provisions: The bill increases the income limit for Medicaid eligibility for pregnant women and infants. It provides for continuous eligibility of a child under Medicaid and the Children's Health Insurance Program (CHIP) until the child becomes three years of age. The bill also increases the CHIP eligibility family income limit.

Hospital Payment Changes: The bill makes funding changes to the Hospital Care for the Indigent (HCI) Program, the Municipal Disproportionate Share Hospital (DSH) Program, and the Medicaid Indigent Care Trust Fund.

HCI Property Tax Levy Revisions: The bill amends the formula in determining a county's HCI property tax levy and the applicable years.

Tax Credit for Offering Health Benefit Plans: The bill establishes a tax credit against the Adjusted Gross Income (AGI) Tax liability, Financial Institutions Tax liability, or the Insurance Premiums Tax liability for qualified taxpayers who make at least one health benefit plan available to their employees for the first time after December 31, 2006.

Tax Credit for Small Employer Qualified Wellness Programs: The bill provides for a tax credit related to small employer qualified wellness programs. It allows an employer to take a tax credit for making a health benefit plan available to the employer's employees for the first two taxable years that the employer makes the health benefit plan available. The bill requires the State Department of Health (ISDH) to establish standards for and certify a small employer qualified wellness program.

Insurance Provisions - Coverage to Age 24: The bill requires health insurers and health maintenance organizations to cover children up to 24 years old upon request.

Group Health Insurance for Small Employers: It also allows certain small employers to join together to purchase group health insurance and allows the Commissioner of the Department of Insurance (DOI) and the Office of the Secretary of Family and Social Services (FSSA) to develop a program to provide for such purchases.

Health Finance Commission: The bill requires the Health Finance Commission to study and report concerning several issues.

The bill makes appropriations. It also makes conforming and technical changes.

Effective Date: Upon passage; January 1, 2007 (retroactive); July 1, 2007; August 1, 2007.

Summary of Net State Impact: *Indiana Check-up Plan:* The bill will increase Cigarette Tax collections by an estimated $187.2 M in FY 2008 and $206.5 M in FY 2009. The bill also establishes the Indiana Check-up Plan Trust Fund and distributes to the Fund from the total increased Cigarette Tax revenues $140.4 M in FY 2008 and $154.8 M. (The balance of the increased Cigarette Tax revenues is to be distributed for other health initiatives, for additional Medicaid provider reimbursement, and for a tax credit for offering health benefit plans.)

The bill appropriates $11 M for each year of the biennium from the Indiana Check-up Plan Trust Fund to the Department of Health for use in childhood immunization programs.

The remainder of funds in the Indiana Check-up Plan Trust Fund is appropriated for the biennium for the purposes of the Fund, which includes the Indiana Check-up Plan, established as a demonstration waiver project under the state Medicaid program. The Plan is to provide health insurance to individuals having an annual household income of not more than 200% of the federal poverty level (FPL). Custodial parents may be added to the eligible population of Medicaid and CHIP and would be considered an eligibility expansion group. Childless adults are typically not eligible for Medicaid unless certain disability or age and income standards are met. The Office would need to demonstrate fiscal neutrality within the program in order to add this group in the demonstration waiver. Medicaid waivers, by definition, must demonstrate fiscal neutrality and are approved and monitored by the Centers for Medicare and Medicaid Services (CMS) for fiscal neutrality through the term of the demonstration. The bill specifies that the Plan is not an entitlement and participation is dependent upon the level of funding appropriated for the Plan.

Hospital Payment Changes: The bill will also freeze hospital payments under the HCI program at FY 2007 levels and discontinue the requirement that the hospitals submit claims for services under the HCI program. The bill increases the level of the transfer of funds from the Medicaid Indigent Care Trust Fund to the Medicaid program from $21 M to $30 M. The bill specifies a payment methodology for supplemental payments to privately owned hospitals and makes other changes to other supplemental and disproportionate share hospital payments.

HCI Tax Levy Revisions: The bill changes the method by which the HCI levy is determined for taxes payable in 2008 and thereafter, removing the computational link to payable hospital claims attributable to each county.

Tax Credit for Offering Health Benefit Plans: The bill establishes a tax credit against the AGI Tax liability, Financial Institutions Tax liability, or the Insurance Premiums Tax liability for qualified taxpayers who make at least one health benefit plan available to their employees for the first time after December 31, 2006. The estimated net impact of the tax credit program is a General Fund revenue loss of $11.1 M in FY 2008 and $12.2 M in FY 2009.

Employer Wellness Tax Credit: The Employer Wellness Program tax credit could potentially reduce revenue by $600,000 to $2.5 M annually beginning in FY 2009. The revenue loss could begin in FY 2008 if taxpayers adjust their quarterly estimated payments.

The cost of Medicaid and CHIP 12-month continuous eligibility for children up to age three years is not known at this time.

The bill also requires a Medicaid State Plan amendment to expand Medicaid eligibility for pregnant women and infants from 150% of the FPL to 200%. This provision would create an entitlement for services to a total population estimated by OMPP to be approximately 14,733 pregnant women and an equal number of infants. Total cost of this provision is estimated to be $160.1 M, or approximately $60.9 M in state General Funds. FSSA reports that this cost can be absorbed within the 5% expansion of the Medicaid budget included in the FY 2008-FY 2009 state budget.

The bill requires the Medicaid State Plan be amended to include presumptive eligibility for pregnant women. FSSA reports the cost of this provision to be negligible.

Employer-sponsored health coverage for children to age 24 is estimated to have a state fiscal impact of $4.6 M.

The range of total expense for the expansion of CHIP eligibility to 300% of the FPL is estimated to be between $31.7 M to $43.2 M in FY 2008. The state General Fund share is estimated to be $12.0 M to $16.4 M at the lower Medicaid FMAP (federal medical assistance percentage) rate since enhanced CHIP funding is capped.

The Indiana Check-up Plan Task Force should be able to be implemented within the resources available to FSSA.

The bill also annually appropriates $1.2 M from the General Fund to the Indiana Tobacco Use Prevention and Cessation Trust Fund for the purpose of tobacco education, prevention, and use control.

Explanation of State Expenditures: *Details on the Indiana Check-up Plan* -

Medicaid Waiver and Conditions for Program Implementation: The bill establishes the Indiana Check-up Plan and requires OMPP to apply for a Medicaid demonstration waiver to develop and implement the Plan. The bill specifies that the Plan is not an entitlement and participation is dependent upon the level of funding appropriated for the Plan. The bill specifies that OMPP may not enroll applicants, approve contracts, or otherwise create a financial obligation for the state other than costs necessary to study and plan for the implementation of the Plan without a specific appropriation made by the General Assembly, which is provided in the bill. The bill further specifies the Plan may not be implemented until an actuarial analysis, reviewed by the Budget Committee and approved by the State Budget Agency, demonstrates that sufficient funding is available to operate the program for at least 5 years. OMPP is authorized to adopt emergency rules to implement the Plan on an emergency basis.

Eligibility: Individuals eligible for the Plan must be over age 18 and under age 65, U.S. citizens, and residents of Indiana for at least 12 months. Eligible individuals may not be eligible for Medicare, or Medicaid as a disabled person. Pregnant women are not eligible for services related to the pregnancy. Individuals must not be eligible for health insurance coverage through an employer, and they must have been uninsured for at least 6 months or uninsured due to a job change. Individuals and married couples must apply for the Plan, be approved by FSSA, and make defined, timely contributions to an individual Health Care Account established to help the individual pay the deductible for health care services offered under the Plan. The Indiana Check-up Plan will add two groups of eligible individuals; custodial parents and childless adults. Custodial parents may be added to the eligible population of Medicaid and CHIP and would be considered an eligibility expansion group. Childless adults are typically not eligible for Medicaid unless certain disability or age and income standards are met. The Office would need to demonstrate fiscal neutrality within the program in order to add this group in the demonstration waiver.

Financial Eligibility: The parent of a child having an annual household income of not more than 200% of the FPL is eligible for the Plan. Single individuals having an annual household income of not more than 200% of the FPL are also eligible. The bill does not require the income to be earned income. Federal income poverty level guidelines for 2007 are included in the table below.

Persons in the Family or Household	100%	200%	300%
1	$10,210	$20,420	$30,630
2	$13,690	$27,380	$41,070
3	$17,170	$34,340	$51,510
4	$20,650	$41,300	$61,950

Terms of Participation: Individuals approved for participation are eligible for 12 months, contingent upon timely payment of the required contribution. At the end of the 12-month period the individual must apply for a renewal in order to continue Plan participation. Certain individuals defined as high risk are required to participate in the high-risk plan, which requires participation by an individual in medical management services and is to be administered by ICHIA. An individual that fails to make a Health Care Account contribution within 60 days of the required payment may be terminated from the Plan. Individuals who are

terminated for nonpayment of the required contributions or who do not renew their participation after the end of the 12-month enrollment period may not reapply for at least 12 months.

Health Care Accounts: Participants in the Plan must have Health Care Accounts. Up to 50% of the required contributions to the accounts may be made by employers withholding after-tax payroll dollars on an employee's behalf, or the contribution may be made directly by an individual in a manner to be prescribed by OMPP. The Health Care Account is to be available to meet the individual's deductible expenses required before the insurance policy purchased on their behalf by the Plan assumes the cost of subsequent medical expenses. The state is required to subsidize the Account based on the income level of the participant.

Health Care Account Contributions: Individuals are required to contribute at least $1,100 per year, but not more than 2% of the individual's annual household income if the household income level is below 100% of the FPL, not more than 3% of the individual's annual household income if the household income level is between 100% and 125% of the FPL, not more than 4% if the household income is between 125% and 150% of the FPL, and not more than 5% if the household income is between 150% and 200% of the FPL. The bill provides that the required contribution for an individual's household includes any contributions required for CHIP, the Medicaid Program, or the Medicare Program. This provision would allow parents to reduce their required 2%, 3%, 4%, or 5% contribution by the amount of CHIP C premiums and CHIP, Medicaid, or Medicare copayments made for members of the household. CHIP C premiums range from $22 to $50 per month depending on the household income level and the number of children in the household. CHIP C children may also have copayments for prescription drugs and emergency transportation services which could be deducted. (CHIP C financial eligibility is established as a household income greater than 150% of FPL but less than 200% FPL.) The bill prohibits Medicaid recipients from participating in the Plan, but a qualifying individual may have a Medicaid recipient as a member of their household. Federal regulations prohibit states from assessing copayments for Medicaid children (less than 150% FPL). Certain Medicaid recipients in the aged, blind, or disabled eligibility categories could have prescription drug copayments assessed. While the bill would prohibit Medicare participants from participating in the Plan, household members may be Medicare-eligible (e.g., an elderly parent or a disabled adult or child), and Medicare-associated premiums, copayments, and deductibles could reduce the individual's required contribution as determined by OMPP. The highest contribution that could be required from any individual would be the minimum dollar amount required for the account of $1,100 annually, or $91.67 per month. The bill addresses each covered individual's requirements and appears to indicate that each covered individual must have a Health Care Account. The bill is not specific with regard to the treatment of contributions and Account requirements for legal spouses.

The bill would require the state to contribute any difference between the calculated required individual contribution and the minimum amount required for contribution to the account of $1,100. The total cost of the subsidy required would be dependent upon the number of individuals enrolling and the level of the required contributions for each enrolled individual.

Withdrawals from the Health Care Account: The Health Care Account is to be used through the year to pay deductible expenses incurred for health care services, excluding $500 for the defined preventive care services, up to the maximum dollar amount required of $1,100. At the end of each 12-month enrollment period, individuals who have received the preventive care services defined by OMPP and who renew their participation in the Plan, will have any unused money remaining in the account applied to reduce the required amount they must contribute to the Account in the next 12-month enrollment period. Individuals who did not participate in the preventive care services requirement and who renew their participation in the Plan, will have only individually contributed money remaining in the Account applied to reduce the next year's required

contribution; state funds contributed to the Account will not be available for this purpose if preventive care services were not received. Individuals no longer eligible for the Plan due to increased income or those choosing not to re-enroll in the Plan may withdraw funds to the extent they were contributed to the Account by the individual. Individuals terminated for failure to make timely Account contributions will have individual contributions remaining in the Account refunded less a 25% penalty. The bill does not specify the disbursement of state funds, penalties, or other money remaining in an Account at the end of the 12-month period that is not refunded, withdrawn as allowed, or applied to the next year's contributions. The bill is not specific with regard to the administrative responsibility for the establishment and operation of the Health Care Accounts.

Covered Services: The Plan is required to provide up to $500 per year of preventive care services, to be defined by OMPP, that are appropriate for the age, gender, and pre-existing conditions of a covered individual. The preventive care services are to be provided at no cost to the covered individual. The bill also specifies that individuals may be held responsible for non-emergency use of hospital emergency department services; individuals may be required to pay for these services outside of the Health Care Account. Appropriate use of emergency department services may be paid from the Account. Services related to pregnancy are not included in the Plan. Dental and vision services will not be covered by the Plan but may be covered under an additional program if the individual pays an additional defined premium that may not exceed 5% of the individual's household income. The bill specifies that the Plan must include mental health services, including substance abuse treatment, inpatient hospital services, prescription drug coverage, emergency services, physician office services, diagnostic services, outpatient services including therapies, comprehensive disease management, home health services, urgent care center services, preventive care services, family planning services including contraceptives, and hospice services. The Office is to determine the manner and extent to which these services are included. The bill specifies that mental health and substance abuse services may include treatment limitations and financial requirements only to the extent that similar limitations and requirements are imposed on services for medical and surgical conditions. The bill further provides that the program policies must comply with any health coverage requirement necessary for an accident and sickness policy issued in the state.

The bill requires the state to annually assume up to a maximum of $500 for defined age, gender, and pre-existing condition preventive health care services at no cost to the participating individuals. The bill does not specify how the benefit is to be administered.

Plan Insurers: Health benefits insurers or health maintenance organizations (insurers) that contract with OMPP to provide health care insurance under the Plan may not deny coverage to an eligible individual who has been approved by OMPP unless the maximum coverage levels are met ($300,000 for the annual individual maximum and $1M for the individual lifetime maximum). Insurers are responsible for claims processing and are required to reimburse providers at rates equal to Medicare reimbursement rates for the services provided or at 130% of the applicable Medicaid reimbursement rate if there is no corresponding Medicare rate. The bill requires that insurer's administrative costs and profit may not exceed 15% of the funds used to provide health insurance coverage under the Plan. The bill further provides that insurers that contract to provide health care insurance under this Plan must also make the same health insurance available to financially eligible individuals that may be waiting for an available Plan slot using the same underwriting and rating practices used for the Plan. Insurers may also offer the Plan product to individuals with income that exceeds the financial eligibility limits for the Plan using standard underwriting procedures. No state subsidy is available for individuals that are otherwise eligible but may be waiting for an Indiana Check-up Plan slot or for individuals who are not financially eligible.

State Employer Premium Assistance Program: The bill permits the Office to develop a health insurance premium assistance program for individuals with a household income of less than 200% of the FPL and who are eligible for health insurance coverage through an employer but who cannot afford the health coverage premiums. The bill specifies that a program established under this provision must include a Health Care Account as a component and provide that an individual's payment to a Health Care Account or for a health insurance premium may not exceed 5% of the individual's annual income.

Indiana Check-up Plan Trust Fund: The bill establishes the dedicated, non-reverting Indiana Check-up Plan Trust Fund to: (1) administer the Plan; (2) provide Plan co-payments (Account subsidies), preventive care services, and insurance premiums; (3) fund tobacco use prevention and cessation programs and childhood immunization programs; and (4) fund programs to promote the general health and well-being of Hoosiers. The Fund is to be administered by FSSA. Money in the Trust Fund may not be transferred, assigned, or moved from the Fund by FSSA, the State Budget Agency, or the State Board of Finance. The expenses of administering the Fund are to be paid from money in the Fund. The Treasurer is authorized to invest money in the Fund in the same manner as other public funds may be invested. The bill specifies that money in the Fund must be appropriated before funds are available for use.

The Trust Fund is to consist of Cigarette Tax revenues designated by the General Assembly to be allocated to the fund; other funds designated by the General Assembly; federal funds available for the purposes of the Fund; and gifts or donations. The bill appropriates $11 M for each year of the biennium from the Indiana Check-up Plan Trust Fund to the Department of Health for use in childhood immunization programs. The remainder of funds in the Indiana Check-up Plan Trust Fund are appropriated for the biennium for the purposes of the Fund.

Indiana Comprehensive Health Insurance Association: The bill requires ICHIA to administer plan benefits for high-risk individuals insured under the plan. The impact of this provision on ICHIA is indeterminable and will depend on the payment negotiated for services and the number of participating individuals assigned to the high-risk group.

Medicaid and CHIP Provisions -

Details on the Expansion of Medicaid Pregnancy-Related Services - The bill requires OMPP to apply for a Medicaid State Plan amendment to expand Medicaid coverage for pregnant women with incomes from 150% of FPL to 200%. A State Plan amendment would create an entitlement status for the new population group.

A Medicaid State Plan amendment could only be applied to the population of pregnant women up to 185% of FPL. However, the state has the flexibility to determine amounts of income that may be disregarded in determining financial eligibility and therefore could effectively implement a Medicaid eligibility expansion to 200% of poverty for all pregnant women. The Plan amendment would also be required to cover the additional group of infants born with Medicaid coverage from birth until one year of age. This is a federal requirement. Under CHIP, fewer than 200 of the expansion group of infants currently receive services subsidized by the state.

Medicaid Expansion Fiscal Impact - Pregnant Women: This provision would create an entitlement for services to a total population estimated by OMPP to be approximately 14,733 pregnant women. The average cost of pregnancy care in the Medicaid program is currently reported to be $8,421. Total cost of this provision is estimated by OMPP to be $124.1 M, or approximately $47.2 M in state General Funds. (This is the total cost to add the population of pregnant women to Medicaid.) FSSA reports that this cost can be

absorbed within the 5% expansion of the Medicaid budget included in the FY 2008-FY 2009 state budget.

Medicaid Expansion Fiscal Impact - Infants: All children born to mothers with Medicaid benefits are eligible to remain on Medicaid until their first birthday. If it is assumed that 14,733 infants become eligible for Medicaid as a result of the expansion for pregnant women, an additional annual cost of $36.0 M, or approximately $13.7 M in state General Funds, would result. FSSA reports that this cost can be absorbed within the 5% expansion of the Medicaid budget.

CHIP Impact - Infants: Under the CHIP C program, all children in families with income between 150% and 200% of FPL can be covered at low cost to families. The premium amounts are between $22 and $50 per month, based on the family income and the number of family members covered. There are also small co-payments for some services. The expansion of eligibility for pregnant women under the Medicaid program up to 200% of FPL would also include the shift of all current CHIP infants, and any subsequently born, to the Medicaid program. CHIP premium revenue would be reduced by the amount being contributed to cover children under the age of one year who are in families with income below 200% but above 150% of FPL. FSSA procurement documents estimated the size of this enrolled population to be 189 infants in CHIP C. If all infants projected to be enrolled in CHIP are assumed to be single children, the maximum annual loss of premium revenue would be approximately $50,000.

Medicaid and CHIP Continuous Eligibility: The bill would provide that children under the age of 3 years would be continuously eligible for 12 months following a determination of eligibility for Medicaid or CHIP. In the December 2002 Medicaid Cost Containment Forecast, savings estimated for the Medicaid Program due to eliminating continuous eligibility for all children were $23.5 M for FY 2005. The cost of re-instituting this provision for children under age 3 years is not known at this time. This provision would apply to currently eligible Medicaid and CHIP children as well as the CHIP expansion group added in this bill, children in families with income greater than 200% but not more than 300% of the FPL.

Medicaid Presumptive Eligibility for Pregnant Women: The bill requires that OMPP apply for a state plan amendment to include presumptive eligibility for pregnant women. This provision would allow physicians to receive payment for services to pregnant women who are presumed to be eligible for Medicaid rather than waiting for eligibility to be determined. This provision would apply to the current population of eligible women plus the proposed expansion group. FSSA reports the cost of this provision to be negligible.

CHIP Income Eligibility Increased to 300% of FPL: The bill would increase the income eligibility for CHIP from 200% to 300% of FPL.

U.S. Census data estimate that 56.7% of all children under the age of 18 live in households with income below 300% of the FPL. If this percentage is assumed to remain constant when 18-year-olds are included, the population of children under the age of 19 living in households between 200% and 300% of FPL is estimated to be 304,700 children. If this population is assumed to be similar in health care needs to the population of children in Medicaid or to the CHIP C population, a range of total expense may be estimated to range from $31.7 M to $43.2 M in FY 2008. The state General Fund share is estimated to be $12.0 M to $16.4 M at the lower Medicaid federal match rate (FMAP) rate. Federal CHIP funds are annually capped and Indiana expends all of the federal CHIP allotment on the current population. The CHIP statute currently authorizes coverage under the program up to 200% of the FPL. However, the state has the flexibility to determine amounts of income that may be disregarded in determining financial eligibility and therefore could effectively implement an eligibility expansion to 300% of poverty for children - other states have expanded to this level. Additionally, the federal CHIP statute and funding expires this year, and the terms of the

reauthorization are unknown at this time.

Medicaid Reimbursement: The Medicaid Program is jointly funded by the state and federal governments. The state share of program expenditures is approximately 38%. Medicaid medical services are matched by the FMAP in Indiana at approximately 62%. The CHIP program receives enhanced federal reimbursement of approximately 74%. The state share of the CHIP Program is approximately 26% for medical services. Administrative expenditures with certain exceptions are matched at the federal rate of 50%.

Hospital Care for the Indigent (HCI) Program Changes: The bill would freeze hospital payments under the HCI program at FY 2007 levels. It would also allow hospitals to once again discontinue submitting claims for the HCI program to OMPP for processing. Hospitals were required to resume submitting claims for purposes of calculating the county property tax levy requirements in FY 2004. OMPP would also realize a decrease in claims processing volume as a result. By way of reference to the volume of work involved, OMPP had approximately 30,922 applications for reimbursement under the HCI program in FY 2006; 11,320 hospital claims were processed for a total amount of $31.3 M priced at Medicaid reimbursement rates. Hospitals are not currently reimbursed for claims, rather they receive HCI add-on payments leveraged for federal reimbursement available within the Medicaid program.

The bill provides that HCI physician and emergency transportation claims would continue to be submitted, processed, and reimbursed for services up to a maximum amount of $3 M per year. This group submitted 30,968 claims that were priced at Medicaid reimbursement rates for $4.4 M in FY 2006. Since the pool of dollars available for reimbursement for this group is capped at $3 M, in FY 2006 each provider's claims were proportionally reduced and paid at approximately 67.86% of the Medicaid rate for the services provided. HCI program administration costs are also payable from the Fund.

The bill specifies that the remainder of the HCI funds (after the $3 M for physicians and transportation services, the $30 M transfer to Medicaid, and the program administration costs) are to be transferred to the Medicaid Indigent Care Trust Fund to be used to make supplemental hospital payments under the HCI privately owned hospital upper payment level (UPL) program and other supplemental payment programs. The Office is authorized to transfer $30 M annually from the Medicaid Indigent Care Trust Fund to the Medicaid program. (Currently the Office transfers $21 M.) In 2007, the gross HCI levy is estimated to raise $61.2 M. Additional funds due to annual growth in the HCI levy would be directed to supplemental hospital payment programs as specified by the bill after the required HCI program expenses and the $30 M transfer to the Medicaid program.

The bill specifies a methodology for privately-owned hospital supplemental payment levels for FY 2006 and FY 2007. The total private hospital supplemental UPL payments for FY 2007 and thereafter are to be capped at the FY 2007 level. After FY 2007, the bill allows the Office flexibility to make Medicaid supplemental hospital payments and DSH payments in the manner that best utilizes the available non-federal share of the funding.

OMPP is required to apply to the U.S. Department of Health and Human Services for approval of an amendment to the state's upper payment limit program and to make changes to the state's DSH program.

Tax Credit Provisions & Cigarette Tax Increase - Department of State Revenue (DOR): The DOR would incur some administrative expenses relating to the revision of tax forms, instructions, and computer programs to incorporate the tax credits and to implement the changes to the Cigarette Tax established in this bill. The DOR's current level of resources should be sufficient to implement these changes.

Tax Credit Provisions - Indiana State Department of Health: The Department of Health is required to establish minimum standards for use by a small employer in establishing a wellness program to improve the health of employees. The ISDH is also to establish criteria to determine if a program meets the minimum standards and a process for certification of a small employer wellness program. The ISDH is required to review programs submitted for certification based on the developed criteria. If a program meets the standards, ISDH is to certify the program as a qualified wellness program for the purposes of the tax credit. It is unknown at this time if the Department can absorb these costs.

Health Coverage for Children to Age 24: As of January 2007, the state enrolled approximately 31,155 state employees in three health benefit plans: M-Plan, Anthem, and Wellborn. Total annual premium increases for the three plans are estimated to be $4.6 M. The actual impact will likely be less. This increase may not necessarily imply additional budgetary outlays since the state's response to increased health benefit costs may include (1) greater employee cost-sharing in health benefits; (2) reduction or elimination of other health benefits; and (3) passing costs onto workers in the form of lower wage increases than would otherwise occur. It is unknown at this time if the state would absorb added costs or pass the costs on to employees.

Background Information-The following estimates are based on adding coverage up to age 24 for Anthem and Welborn. Estimates for M-Plan are based on coverage until age 26. (1) Anthem reports that to add coverage up to 24 would result in a $7.89 increase pmpm. Currently, 20,092 employees are enrolled in an Anthem program. Applying the 2.28 members per employee would result in an Anthem total membership of 45,810. Applying the $7.89 increase per member would result in an increase of $361,440 per month with an annual increase of $4,337,290. (2) M-Plan reports that to add coverage up to 26 would result in a $0.45 increase per employee per month. Currently, 9,797 employees are enrolled in M-Plan. Applying the $0.45 increase per employee would result in an increase of at most $4,408 per month with an annual increase of at most $52,903. (3) Welborn reports that to add coverage up to 24 would result in a $6.94 increase pmpm. Currently, 1,266 employees are enrolled in Welborn. Applying the 2.28 members per employee would result in a total membership of 2,886. Applying the $6.94 increase per member would result in an increase of $20,028 per month with an annual increase of $240,346.

Group Health Insurance for Small Employers: The bill allows certain small employers to join together to purchase group health insurance and allows the Insurance Commissioner and FSSA to develop a program and promulgate rules to provide for such purchases. The bill does not provide any additional resources to the DOI to fulfill the requirements of the provisions.

Health Finance Commission: The bill requires the Health Finance Commission to study the following hospital issues during the 2007 interim: (1) whether the Gary, Indiana, acute care hospital would benefit from conversion to a governmental hospital; (2) ways in which the state can encourage physicians to practice in certain hospital settings; (3) the manner in which a not-for-profit hospital could be converted to a county or municipal hospital; and (4) federal guidelines concerning county hospitals and intergovernmental transfers. During the 2006 interim, the Health Finance Commission spent approximately $7,800 and held two meetings. Legislative Council resolutions in the past have established budgets for interim study committees in the amount of $16,500 per interim for committees with 16 members or more, such as the Health Finance Commission.

Explanation of State Revenues:

Cigarette Tax Provisions - This bill will increase Cigarette Tax collections by an estimated $187.2 M in FY 2008 and $206.5 M in FY 2009. This bill changes the Cigarette Tax: (1) rate; (2) stamp discount rate; and

(3) distribution formula. The rate is increased by $0.44, and the stamp discount changed from 1.2% of the tax rate (approximately six-tenths of a cent per pack) to $0.012 per pack. The distribution formula is also adjusted to distribute the net revenue increase after the rate increase and the stamp discount increase to four health-related programs. The distribution percentages for the current funds are also adjusted to hold those funds harmless for both the rate increase and the stamp discount increase. The table below lists the various increases, the revenue changes resulting from each increase, and the changes to the distribution formula. The increase in the Cigarette Tax rate and the stamp discount rate are effective July 1, 2007, while the distribution formula is effective August 1, 2007. This is due to the month delay between tax collections and tax remittances.

CIGARETTE TAX CHANGES			***Revenue Change (in millions)***	
	Current	***Bill***	***2008***	***2009***
Cigarette Tax Rate (per pack)	*$0.555*	*$0.995*	*$189.5*	*$209.0*
				Revenue Change
	Current	***Bill***	***2008***	***2009***
Stamp Discount	*1.20% of tax*	*$0.012 per pack*	*(2.5)*	*(2.5)*
				NET Revenue Change
	Current %	***Bill %***	***2008***	***2009***
General Fund	*83.97%*	*53.68%*	*0.0*	*(0.2)*
Mental Health Fund	*0.94%*	*0.60%*	*0.0*	*0.0*
Cigarette Tax Fund	*6.60%*	*4.22%*	*0.0*	*0.0*
Pension Relief Fund	*8.49%*	*5.43%*	*0.0*	*0.0*
Health Initiative	*0.00%*	*4.10%*	*21.2*	*23.5*
Medicaid- Provider Reimbursement	*0.00%*	*2.46%*	*12.8*	*14.1*
Health Benefit Offering Tax Credit	*0.00%*	*2.46%*	*12.8*	*14.1*
Indiana Check-up Plan Trust Fund	*0.00%*	*27.05%*	*140.4*	*154.8*
TOTAL INCREASE IN DISTRIBUTED REVENUE			***$187.2***	***$206.3***

Please note that 2008 revenue totals are adjusted for 11 months of collections due to the timing of remittances. Also, the decrease in the state General Fund revenue in FY 2009 is due to the estimated decrease in cigarette sales due to an increase in price from the rate increase.

Tax Credit for Offering Health Benefit Plans: The bill establishes a tax credit against the Adjusted Gross Income Tax liability, Financial Institutions Tax liability, or the Insurance Premiums Tax liability for qualified taxpayers who make at least one health benefit plan available to their employees for the first time after December 31, 2006. The estimated net impact of the tax credit program is summarized in the table below.

Revenue Base (million $)	FY 2008	FY 2009	FY 2010	FY 2011
Adjusted Gross Income Tax				
Employer Health Benefit Plan Tax Credit*	(1.4)	(1.4)	(1.2)	0
Employee Health Benefit Plan Premium Exclusion**	(14.0)	(15.5)	(17.0)	(18.8)
Insurance Premiums Tax	4.3	4.7	5.2	5.8
Net Revenue Gain (Loss)	(11.1 M)	(12.2 M)	(13.0 M)	(13.0 M)

*The tax credit affects the AGI Tax, Financial Institutions Tax, and Insurance Premiums Tax.
**The exclusion affects the Individual Adjusted Gross Income Tax.

The fiscal impact of this tax credit program is a function of the following:

(1) Revenue loss from the tax credits claimed by employers making credit-eligible health benefit plans available to their employees. The amount of credits ultimately claimed will depend upon the benefit take-up rate of employees as the credit may be claimed only for employees who enroll in the employer-provided health benefit plan. The estimate assumes full participation from employers currently not offering health benefits to their employees and a 10% take-up rate among employees.

(2) Reductions in AGI Tax paid by employees purchasing health benefits through these plans with pretax income. Under a health benefit plan that qualifies an employer for the tax credit, the employee would pay his or her share of the premium cost with pretax dollars. This would reduce the employee's taxable income and decrease revenue from the Individual AGI Tax.

(3) Increased Insurance Premium Tax revenue on new health insurance premiums written in Indiana as a result of the new employer-provided health benefit plans.

Some of the FY 2008-FY 2011 fiscal impact (tax credits, premium exclusions, and premium taxes) could be shifted to a later period to the extent that employers delay initially offering health benefits to employees until 2008 and after. In addition, the fiscal impact (tax credits, premium exclusions, and premium taxes) could be increased somewhat if additional employers arise due to business start-ups or business expansions. The extent to which these changes could occur is indeterminable.

The tax credit is nonrefundable and may be claimed in each of the first two years that an employer makes a health benefit plan available to employees. The tax credit does not apply to employers who offer employee coverage under a self-funded plan that complies with ERISA. In addition, participation by employees in the health benefit plan must be voluntary for the employer to qualify for the tax credit. The credit is equal to $50 per employee enrolled in the employer's health benefit plan, up to a maximum of $2,500 per year in the first two years the plan is offered. The tax credit may be carried forward to succeeding taxable years but may not be carried back. If the taxpayer is a pass through entity and does not have a tax liability, the credit could be taken by shareholders, partners, or members of the pass through entity in proportion to their distributive income from the pass through entity. An employer claiming the credit must offer health insurance for at least 24 consecutive months after the taxable year in which the health benefit plan is initially offered. The bill contains a "claw-back" provision where employers who fail to meet this requirement have to pay back the tax credit. Since the tax credit is effective beginning in tax year 2007, the fiscal impact could potentially

begin in FY 2008.

The bill defines a "health benefit plan" as a health insurance policy or contract with an HMO that satisfies the requirements of Section 125 of the Internal Revenue Code. Section 125 allows an employee to pay his or her share of the premium for an employer-provided health benefit with pretax dollars which reduces the employee's taxable income and FICA contribution and the employer's FICA contribution and potentially unemployment insurance and worker's compensation payments. While the bill allows a qualified taxpayer to pay any or all of the health insurance premium cost, it does not require such payments.

Small Employer Qualified Wellness Program Tax Credit: The bill establishes a tax credit against the AGI Tax liability, Financial Institutions Tax liability, or the Insurance Premiums Tax liability for expenditures by "small employers" who provide employee wellness programs certified by the ISDH. A small employer is an employer of 2 to 100 employees. The tax credit could potentially reduce revenue by $260,000 to $1.1 M annually beginning in FY 2008 assuming that most firms currently offering employee wellness programs obtain ISDH certification. Cost inflation and employment trends suggest that the revenue loss could potentially grow by 1% to 2% per year. In addition, the revenue loss could increase beyond these levels to the extent that firms currently not offering wellness programs do so and obtain ISDH certification.

The tax credit is nonrefundable and applies to employers who provide employee wellness programs certified by the ISDH and at minimum which reward employees for appropriate weight loss, smoking cessation, and pursuit of preventative care services. The tax credit is equal to 50% of the cost incurred by the taxpayer in providing the wellness program during the taxable year. The tax credit may be carried forward to succeeding taxable years, but may not be carried back. If the taxpayer is a pass through entity and does not have a tax liability, the credit could be taken by shareholders, partners, or members of the pass through entity in proportion to their distributive income from the pass through entity. Since the credit is effective beginning in tax year 2007, the fiscal impact could potentially begin in FY 2008.

Explanation of Local Expenditures: *Health Coverage for Children to Age 24:* This bill requires a policy of accident and sickness insurance and an HMO contract to provide coverage for the child up to 24 at the request of the policyholder, certificate holder, or subscriber. This provision will affect expenditures for health insurance for local units. Whether the bill will increase or decrease expenditures is unknown and will vary by unit.

Explanation of Local Revenues: *Tax Credit for Offering Health Benefits:* The tax credit program could potentially increase the number of taxpayers paying the premium cost for employer-provided health benefits with pretax income (see *Explanation of State Revenues)*. This would reduce the taxable income of some taxpayers. As a result, counties imposing a local option income tax (CAGIT, COIT, CEDIT) could experience a significant decrease in revenue from these taxes.

HCI Property Tax Levy Changes: Under current law, the property tax levy payable in 2008 for the HCI fund in each county is equal to the 2007 levy multiplied by the three-year average growth in the county's assessed value. For taxes payable in 2009 and later, the levy would have been equal to a three-year rolling average of payable claims attributed to the county, subject to a maximum levy based on the county's assessed value growth.

This bill removes the computational link to payable claims. Under this bill, beginning with taxes payable in 2008, the levy for a year will equal the previous year's levy, increased by the statewide average assessed value growth quotient (AVGQ). The statewide AVGQ is actually an income-based index equal to the six-year

average growth rate in Indiana nonfarm personal income. The AVGQ is 4.0% in CY 2007, and is estimated at 3.8% in CY 2008, 4.3% in CY 2009, and 4.6 % in CY 2010.

The estimated maximum levy under current law is estimated at $63.7 M for 2008, $66.3 M for 2009, and $69.0 M for 2010. The estimated levy under this bill is estimated at $63.5 M for 2008, $66.2 M for 2009, and $69.3 M for 2010.

HCI collections are transferred by the counties to the state HCI Fund for reimbursement of eligible physician and transportation provider claims up to an amount of $3 M. The balance of the fund is transferred to the Medicaid Indigent Care Trust Fund.

State Agencies Affected: DOI; ICHIA; Legislative Council; Legislative Services Agency; DOR; ISDH.

Local Agencies Affected: Local governments and school corporations; Counties with local option income taxes.

Information Sources: Legislative Services Agency; Christy Tittle, Benefits Director, Department of Personnel, 317-232-3241; OFMA Corporate Income Tax database; Kaiser Family Foundation, *Employer Health Benefits 2006 Annual Survey*, available at http://www.kff.org and *State Health Facts Online* available at http://www.statehealthfacts.kff.org/; Bureau of the Census, *County Business Patterns, 2004*; The Urban Institute, Could Subsidizing COBRA Health Insurance Coverage Help Most Low-Income Unemployed?; 2006 Annual Membership eSurvey, Wellness Councils of America, http://www.welcoa.org/; Employer Health Benefits Annual Survey, 2005 & 2006, Kaiser Family Foundation, http://www.kff.org/; State and Area Employment, Hours, and Earnings, U.S. Bureau of Labor Statistics, http://www.bls.gov.

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